STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDIN	LE CONSTRUCTION IG 00	(X3) DATE SURVEY  COMPLETED		
		155689	B. WING		02/18/2016	
	PROVIDER OR SUPPLIE		240	EET ADDRESS, CITY, STATE, ZIP ( )0 COLLEGE AVE ISHEN, IN 46526	CODE	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PRECTION (X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE COMPLETIC	ON
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAC	DEFICIENCY)	DATE	
F 0000						
Bldg. 00	Complaints INC IN00193652.  Complaint IN00 Federal/State de F157, F282, F3  Complaint IN00 Federal/State de F157, F282, F3  Survey dates: F 2016.  Facility number Provider number AIM number: 1  Census bed type SNF: 14  SNF/NF: 166  Total: 180  Census payor ty Medicare: 8  Medicaid: 127  Other: 45  Total: 180	20193288 - Substantiated. eficiencies are cited at 23 and F309.  20193652 - Substantiated. eficiencies are cited at 23 and F309.  ebruary 16, 17 and 18,  2000091  er: 155689  200290080  ee:	F 0000	Please accept this Pla Correction as our facil Credible Allegation of for our Recertification Licensure Survey cond February 18, 2016. Submission of this Pla Correction is not an ac Courtyard Healthcare the deficiencies allege survey are accurate or depict the quality of nu and services provided residents of our facility of correction is being a solely because doing a required by state and a Considering the volum and severity of the alled deficient practices note CMS-2567, Courtyard Healthcare Center res requests a desk review survey. If approved, w willing to provide any a documentation reques including, but not limite education records, pol procedures, checklists that have been comple revised or implemente this plan of correction.	ity's compliance and State cluded on  n of dinission by Center that d in the that they arsing care to the This plan submitted so is federal law. ie, scope, iged din the pectfully v for this ve would be and all ted ed to: icies and , and forms eted, d as part of	
	These deficience	ies reflect State findings				
1	I		1	1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000091

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION	IDENTIFICATION NUMBER:  155689	A. BUILDING 00  B. WING		COMPI 02/18	LETED
NAME OF I	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COD 00 COLLEGE AVE	3	
COURTY	'ARD HEALTHCARI	E CENTER		SHEN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION DATE
	cited in accordan 16.2-3.1.	ce with 410 IAC				
		• •				
F 0157 SS=D Bldg. 00	Quality Review completed by 14454 on February 25, 2016.  483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED 155689 B. WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE COURTYARD HEALTHCARE CENTER GOSHEN. IN 46526 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG the resident's legal representative or interested family member. Based on record review and interview, F 0157 F 157 NOTIFY OF 03/17/2016 CHANGES(INJURY/DECLINE/R the facility failed to provide timely OOM, ETC) This facility will physician and power of attorney immediately inform the resident; notification for a resident who had consult with the resident's sustained a fall that resulted in a femur physician; and if known, notify the resident's legal representative or fracture and required hospitalization and an interested family member lower leg amputation for one of three when there is an accident residents reviewed for accidents. involving the resident which (Resident B) results in injury and has the potential for requiring physician intervention; a significant change Finding includes: in the resident's physical, mental, or psychosocial status (i.e., a On 2/16/16 at 1:00 P.M., the clinical deterioration in health, mental or record for Resident B was reviewed. psychosocial status in either life threatening conditions or clinical Resident B was admitted to the facility complications); a need to alter on 3/30/11. Diagnoses included but were treatment significantly (i.e., a not limited to, Alzheimer's disease, need to discontinue an existing form of treatment due to adverse muscle weakness generalized, pulmonary consequences, or to commence a heart disease and chronic obstructive new form of treatment); or a pulmonary disease. decision to transfer or discharge the resident from the facility. This facility will also promptly notify the An annual Minimum Data Set (MDS) resident and the resident's legal assessment, reference date of 12/5/15, representative or interested family indicated Resident B required extensive member when there is a change assist of 2 people for transfers and did not in room or roommate assignment as specified in483.15(e)(2); or a ambulate The MDS assessment further change in resident rights under indicated Resident B had a Brief Federal or State law or Interview for Mental Status (BIMS) score regulationsas specified in of 3 which indicated severe cognitive paragraph (b)(1) of this section. The facility will record and impairment.

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A care plan, created on 03/30/15,

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periodically update the address and phone number of the

resident's legal representative or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155689	B. W	ING		02/18/2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	₹			OLLEGE AVE	
COLIDTY	ARD HEALTHCAR	DE CENTED			EN, IN 46526	
COURT	ARD HEALTHCAN	RE CENTER		GOSHE	EN, IN 40320	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	indicated, but w	as not limited to, " At			interested family member.	
	risk for falls r/t [related to] high risk			Corrective Action: Upon		,
	medication use.	impaired memory,			observing edema in resident B	i's
		d inability to stand			left knee, LPN2 notified the physician and the resident's P	OA
		sks Hoyer Lift for			of the change of condition	
		-			on1/19/16 at 7:45pm. RN #1	
		assistDate Initiated:			received disciplinary action for	
	05/05/13"				failure to notify the physician a	
					guardian on 1/19/16at 3:30pm	
	A resident care	guide, dated 1/19/16,			after the incident occurred. Sh	
	indicated "[Resident B] Transfer Assist				completed applicable education	n
	H [Hoyer lift]"				prior to returning to work.	
					Howothers are identified: All	
	A nursing progr	ess note, dated 1/20/16 at			residents have the potential to affected by this alleged deficie	
					practice.	""
	, , , , , , , , , , , , , , , , , , ,	icated " Nurse called to			PreventativeMeasures:	
		dema noted to Left knee.			Licensed nurses were educate	ed
	Left knee confir	med swollen. Resident			on notification of changes. The	
	received schedu	led dose of			hour report sheet was revised	to
	acetaminophen	[a pain medication]. MD			encompass this information ar	
	[medical doctor]	notified and received			will be reviewed by staff at eve	•
	-	o left knee. POA [power			change of shift. Monitoring	
	1	fied. Confirmed			Conditions requiring physician	
					resident and legal representati or interested family member	ve
	_	ID ordered transfer to ER			notification will be audited by t	he
		m]. Resident sent to			Director of	
	-	ospital]. Report called			Nursing/Designee. This audit v	vill
	into [name of lo	cal hospital] ER"			review resident changes and	
					notification 5x weekly for the fi	
	A "Fall Scene Ir	nvestigation Report"			month, 3x weekly for 3 months	
		te of Fall: 1/19/16Time			and 2x weekly for two months.	
	of Fall: 3:30 PMStaff witness presentFall Summary: Fall to the floor (witnessed) Fall Location: Resident				Results of this audit will be presented to QAPI for need fo	_
					further monitoring. Date of	
					Completion: March 17, 2016.	
		s resident doing during or				
	just prior to fall:	Transfer assisted by				
	staff What tvn	e of assistance was				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	ì í	JILDING	nstruction 00	(X3) DATE COMPL 02/18/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	resident receiving less than per care be the root causes [Certified Nursing correct mode to residentSignature [Testing and Testing and	g at time of fall: Assisted e planWhat appears to of the fall? CNA ag Assistant] did not use transfer are [Registered Nurse ime: 1/19/16"  dated 1/19/16 at 19:45 cated "Incident ent's roomPerson t: [Licensed Practical sing description: Nurse of assess edema noted to knee confirmed swollen on Taken: Resident ed dose of MD notified and for xray to left knee. POA med displacement. [name of local type: unable to el of Pain: PAINAD ee Occasional Moan or xpression: 2 Facial y Language: 2Rigid, Knees Pulled Up, Pulling y, Striking Out Distracted or Reassured chMental Status: onPredisposing						
	11anster[816] W	imesses. [name of						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		UILDING	nstruction 00	(X3) DATE COMPL 02/18/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2400 COLLEGE AVE  GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	resident up for de resident by myses started sitting do on floor with leg in charge of resident Practical Nurse anotified: Family 1/19/2016 20:12 [name] 1/19/201  A Radiology repindicated " Confemur displaced  A [name of local report, dated 1/2 year old who has last year had an another home fracturing She was evaluated physician] orthous dementia and imbones her rehabile essentially 0. At caregiver decision amputation. The not speak"	ement: " I was getting inner and transferred elf with gait belt. She wn during turn and fell is bent. I notified nurse dent [name of #Licensed #1]Agencies/People Member [name] [8:12 P.M.]Physician 6 19:50 [7:50 P.M.]"  ort, dated 1/19/16, inclusion: Acute distal fracture"  I hospital] consultation 0/16, indicated " 81 is been immobile for the accident at the nursing ther supracondylar femur.						
	was conducted v Nurse) #1. RN #	th RN (Registered to indicated she had been to the around 3:30 P.M. on						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	î í	UILDING	nstruction 00	(X3) DATE COMPL <b>02/18</b> /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	a transfer. Reside wheelchair upon #1 indicated she checks, vitals and found nothing alter further indicated her assessment in record or notify of attorney of the the fall to the one of her shift. RN busy at that time excuse but it's traindicated she show unit manager, phattorney, start and reassess the reside that on the evening 7:30 P.M., she was conducted we practical Nurse) that on the evening 7:30 P.M., she was to come to Reside her knee, CNA # swollen and laid #2 indicated that found Resident I and displaced but determine at the displacement we was still wearing	:00 A.M., an interview with LPN (Licensed #2. LPN #2 indicated ing of 1/19/16 around ras requested by CNA #1 lent B's room to assess [1 indicated it was [position] funny. LPN upon assessment she B's knee to be swollen						

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155689	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 02/18/2016
	PROVIDER OR SUPPLIER  'ARD HEALTHCARE CENTER	STREET A 2400 CO GOSHE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	then notified the Nurse Practitioner, the Power of Attorney and the Director of Nurses.			
	On 2/16/16 at 1:00 P.M., the Director of Nurses provided the policy, "Assessing Falls and Their Causes," revision date October 2010, and indicated it was one currently used by the facility. The policy indicated "4. Notification of the physician and family as indicated"  This Federal tag relates to Complaints IN00193288 and IN00193652.  3.1-5(a)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED
		155689	B. W	ING		02/18/2016
NAME OF I	DROWINED OF GUIDNI 1ED	1		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			2400 C	OLLEGE AVE	
	ARD HEALTHCAR		1	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	E 0/	TAG		DATE
		review and interview,	F 02	282	F 282 SERVICES BY QUALIFIED PERSONS/PER	03/17/2016
	1	I to ensure a resident was			CARE PLAN Services provide	hah
	transferred accor	ding to the plan of care			or arranged by this facility will	
	to prevent an acc	eident that resulted in a			provided by qualified persons	
	femur fracture th	at required			accordance with each residen	
	hospitalization as	nd lower leg amputation			written plan of care. Correc	
	_	residents reviewed for			Action: Resident B is transfer	
	accidents. (Residents)				per her written plan of care. C	
		,			#1's employmentat this facility was terminated. <b>How others</b>	
	Finding includes	·			are identified: All residents h	
	i manig merades	•			the potential to be affected by	
	On 2/16/16 at 1:00 P.M., the clinical				alleged deficient practice.	
					Preventative Measures: The	
		ent B was reviewed.			CNA/Nurse new employee	
		admitted to the facility			orientation check off was revis	sed
	· ·	gnoses included but were			to include reading and interpreting the information	
	not limited to, A	lzheimer's disease,			included on the resident care	
	muscle weakness	s generalized, pulmonary			guides. A new policy and	
	heart disease and	l chronic obstructive			procedure was developed to	
	pulmonary disea	se unspecified.			define the development and	
	_	_			maintenance of the care guide	
	An annual Minir	num Data Set (MDS)			Nursing staff was re-educated and tested on following the pla	
		rence date of 12/5/15,			of care. <b>Monitoring:</b> The	A11
		nt B required extensive			Director of Nursing/Designee	will
		e for transfers and did not			complete random audits on	
		IDS assessment indicated			nursing staff following the plar	
					care 5x weekly for the first mo	
		Brief Interview for			3x weekly for 3 months and 2x	
	,	SIMS) score of 3 which			weekly for two months. Result of this audit will be presented.	
	indicated severe	cognitive impairment.			QAPI for need for further	
					monitoring. Date of	
	A care plan creat	ted on 03/30/15			Completion: March 17, 2016	
	indicated, but wa	as not limited to, " At				
	risk for falls r/t [	related to] high risk				
	medication use,	impaired memory,				
		d inability to stand				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		ì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>02/18</b> /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
COURTY	ARD HEALTHCAR	E CENTER		1	N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ТЕ	(X5) COMPLETION DATE
		sks Hoyer Lift for assistDate Initiated:					
	,	guide, dated 1/19/16, sident B] Transfer Assist					
	01:09 A.M., indiroom to assess e Left knee confirmore ceived schedul acetaminophen [ [medical doctor] order for x-ray to of attorney] notic displacement. M [emergency room [name of local h into [name of local h	a pain medication]. MD notified and received be left knee. POA [power fied. Confirmed D ordered transfer to ER m]. Resident sent to ospital]. Report called cal hospital] ER"					
	indicated " Da' of Fall: 3:30 PM presentFall Su (witnessed) Fa roomWhat was just prior to fall: staff What type resident receiving less than per care be the root cause	vestigation Report" te of Fall: 1/19/16TimeStaff witness mmary: Fall to the floor ll Location: Resident s resident doing during or Transfer assisted by e of assistance was g at time of fall: Assisted e planWhat appears to e of the fall? CNA ng Assistant] did not use					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155689		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/18/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2400 COLLEGE AVE  GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E NATE	(X5) COMPLETION DATE	
	correct mode to residentSignate #1]Date and T	ure [Registered Nurse						
	(7:45 P.M.), indication: Resider Preparing Report Nurse #2] Indicate Action received schedul Acetaminophen. received order for notified. Confirm Resident sent to hospital] Injury determine Lev [sic]: 6 Negative Vocalization: 1 Groan Facial E Grimacing Bod Fists Clenched, I or Pushing Away Consolability: 1 by Voice or Tou Oriented to Perse Situation Factors Transfer[sic] We CNA] Relation: 1/19/2016 State resident up for details and series with the series of	MD notified and or x-ray to left knee. POA ned displacement. [name of local type: unable to el of Pain: PAINAD re Occasional Moan or xpression: 2 Facial y Language: 2Rigid, Knees Pulled Up, Pulling y, Striking Out Distracted or Reassured chMental Status: onPredisposing s: OtherDuring						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE ( COMPL		
		155689	B. W.	ING		02/18/	2016
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
COURTY	ARD HEALTHCAR	E CENTER			OLLEGE AVE IN, IN 46526		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC INCRETEVING DEFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	(X5) COMPLETION
PREFIX TAG	started sitting do on floor with leg in charge of resid Practical Nurse # notified: Family 1/19/2016 20:12 [name] 1/19/201  A Radiology rep indicated " Confemur displaced  A [name of local report, dated 1/2 year old who has last year had an a home fracturing She was evaluate physician] orthoodementia and im bones her rehabile essentially 0. After caregiver decision amputation. The not speak"  On 2/17/16 at 10 was conducted with Nurse 1 and	wn during turn and fell s bent. I notified nurse dent [name of #Licensed #1]Agencies/People Member [name] [8:12 P.M.]Physician 6 19:50 [7:50 P.M.]"  ort, dated 1/19/16, nclusion: Acute distal fracture"  hospital] consultation 0/16, indicated " 81 s been immobile for the accident at the nursing her supracondylar femur.		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	TE .	COMPLETION DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155689	B. W.	ING		02/18/	2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
COURTY	ARD HEALTHCAR	E CENTER			OLLEGE AVE :N, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		d range of motion and		_			
		pnormal at the time. She					
		she did not document					
		n the resident's clinical					
	<del>-</del>	the physician and power					
		e fall nor did she report coming nurse at the end					
		#1 indicated "I was					
		, I know it's a poor					
	excuse but it's true"						
	On 2/17/16 at 11:00 A.M., an interview						
		vith LPN (Licensed					
	· · · · · · · · · · · · · · · · · · ·	#2. LPN #2 indicated					
		ng of 1/19/16 around					
		as requested by CNA #1 ent B's room to assess					
		1 indicated it was					
	· ·	funny. LPN #2 indicated					
		nent she found Resident					
	*	vollen and displaced but					
	she could not de	termine at the time how					
	far up the displac	cement went because					
	Resident B was s	still wearing her pants					
	_	n a wheelchair. She					
		n notified the Nurse					
	•	Power of Attorney and					
	the Director of N	lurses.					
	On 2/17/16 at 9·	00 A.M., an interview					
		vith the Director of					
		ector of Nurses indicated					
	that CNA#1 had	completed the facilities					
	nurse aide trainii	ng course and was					

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	OF CORRECTION IDENTIFICATION NUMBER:  155689	A. BUILDING B. WING	<u>00</u>	COMPLETED 02/18/2016
	PROVIDER OR SUPPLIER  'ARD HEALTHCARE CENTER	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	educated on how to perform a Hoyer lift transfer. She further indicated CNA #1 was released from her employment at the facility for improperly transferring Resident B.			
	This Federal tag relates to Complaints IN00193288 and IN00193652.			
	3.1-35(g)(2)			
F 0309 SS=G Bldg. 00	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLET			ETED		
		155689	B. W	ING		02/18/2	2016	
		l .		STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	8			OLLEGE AVE			
COLIRTY	ARD HEALTHCAR	PE CENTER			EN, IN 46526			
				GOSITE	_11, 111 40320			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Based on record	review and interview,	F 03	309	F 309 PROVIDE		03/17/2016	
	the facility failed	d to ensure staff			CARE/SERVICESFOR HIGHE			
	completed an ad	equate assessment and			WELL BEING This facility wil	l l		
	-	ervices for a resident			provide our residents with the	_		
	1	ed a fall that resulted in a			necessary care and services tattain or maintain the highest	۱ ا		
					practicable physical, mental, a	ind		
	femur fracture a	•			psychosocial well-being, in			
	_	and lower leg amputation			accordance with the			
		residents reviewed for			comprehensive assessment a	nd		
	accidents. (Resi	ident B)			plan of care. Corrective			
					Action: Resident B received a			
	Finding includes	S:			comprehensive assessment a	fter		
	On 2/16/16 at 1:00 P.M., the clinical				returning from the hospital on			
					1/23/16 and her plan of care was revised. Resident B receives			
		ent B was reviewed.			necessary care and services to			
					maintain her highest practicab			
		admitted to the facility			physical, mental, and			
		gnoses included but were			psychosocial well-being. Ho	w		
	not limited to, A	Izheimer's disease,			others are identified: All			
	muscle weaknes	s generalized, pulmonary			residents have the potential to	be		
	heart disease and	d chronic obstructive			affected by this alleged deficie	ent		
	pulmonary disea	ise.			practice. <b>Preventative</b>			
					Measures: Licensed nurses			
	An annual Minis	mum Data Set (MDS)			were educated on post fall	nt		
					procedure including assessment notification to physician for time			
		rence date of 12/5/15,			services, notification to interes	-		
		ent B required extensive			family or legal representative,			
		e for transfers and did not			timely documentation in the			
	ambulate. The M	IDS assessment indicated			clinical record. The fall incider	nt		
	Resident B had a	a Brief Interview for			report was revised to adequate	ely		
	Mental Status (E	BIMS) score of 3 which			capture all the assessment			
	`	cognitive impairment.			findings. The CNAs were	_		
					educated on the importance of			
	A core plan eres	atad on 02/20/15			not moving the resident prior to the licensed nurse completing			
	•	ated on 03/30/15,			assessment. <b>Monitoring:</b>			
	•	as not limited to, " At			Director of Nursing/Designee			
	_	related to] high risk			audit post fall documentation f			
	medication use,	impaired memory,			complete assessments,			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MULTIP A. BUILDIN B. WING		STRUCTION  00	(X3) DATE S COMPL 02/18/	ETED
	PROVIDER OR SUPPLIER		240	00 CO	DDRESS, CITY, STATE, ZIP CODE LLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Interventions/Ta transfers with 2 a 05/05/13"  A resident care gindicated "[Rest H [Hoyer lift]'  A nursing progred 01:09 A.M., indicated "ceived schedul acetaminophen [medical doctor] order for x-ray to of attorney] notificated displacement. M [emergency room [name of local he into [n	ess note, dated 1/20/16 at cated " Nurse called to dema noted to Left knee. med swollen. Resident ed dose of a pain medication]. MD notified and received o left knee. POA [power fied. Confirmed D ordered transfer to ER in]. Resident sent to ospital]. Report called eal hospital] ER"			subsequent services, and physician notification. This auwill become a facility practice. addition the Director of Nursing/Designee will observe licensed nurses conduct assessments post fall when the occurrence happens and nurse management staff is present in the facility. This audit will continue for 6 months and rest of this audit will be presented to QAPI for need for further monitoring. Date of Completion: March 17, 2016.	e e e n ults	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		155689	B. W		00	02/18/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				OLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ng Assistant] did not use	+	TAG	DLI ICILICI I		DATE
	correct mode to	2					
		are [Registered Nurse					
	#1]Date and T						
	mijDate and i	inic. 1/19/10					
	A "Fall" report, o	dated 1/19/16 at 19:45					
	(7:45 P.M.), indi	cated "Incident					
	Location: Reside	ent's roomPerson					
	Preparing Repor	t: [Licensed Practical					
	Nurse #2] Nurs	sing description: Nurse					
	called to room to	assess edema noted to					
	Left knee. Left l	knee confirmed swollen					
	Immediate Actio	n Taken: Resident					
	received schedul	ed dose of					
	•	MD notified and					
		or x-ray to left knee. POA					
		ned displacement.					
	Resident sent to	-					
	hospital]Injury	• •					
		el of Pain: PAINAD					
	[sic]: 6Negativ						
		Occasional Moan or					
		xpression: 2 Facial					
	_	y Language: 2Rigid,					
		Knees Pulled Up, Pulling					
	or Pushing Away	•					
		.Distracted or Reassured					
	*	chMental Status:					
		onPredisposing					
	Situation Factors	<del>-</del>					
		itnesses: [name of					
	CNA] Relation:						
		ement: " I was getting					
	resident up for d	inner and transferred					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155689		A. BUILDING  B. WING	00	COMPLETED 02/18/2016
	PROVIDER OR SUPPLIER  (ARD HEALTHCARE CENTER	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	resident by myself with gait belt. She started sitting down during turn and fell on floor with legs bent. I notified nurse in charge of resident [name of #Licensed Practical Nurse #1]Agencies/People notified: Family Member [name] 1/19/2016 20:12 [8:12 P.M.]Physician [name] 1/19/2016 19:50 [7:50 P.M.]"  A Radiology report, dated 1/19/16, indicated " Conclusion: Acute distal femur displaced fracture"  A [name of local hospital] consultation report, dated 1/20/16, indicated " 81 year old who has been immobile for the last year had an accident at the nursing home fracturing her supracondylar femur. She was evaluated by [name of physician] orthopedics and between her dementia and immobility and brittle bones her rehabilitation potential was essentially 0. After discussing with her caregiver decision was made for an amputation. The patient apparently does not speak"  On 2/17/16 at 10:15 A.M., an interview was conducted with RN [Registered Nurse] #1. RN #1 indicated she had been notified by CNA #1 around 3:30 P.M. on 1/19/16, of a fall that had occurred during a transfer. Resident B was sitting in her wheelchair upon entry to her room. RN			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155689  A. BUILDING B. WING			COMPL 02/18/	ETED	
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
COURTY	'ARD HEALTHCARI	E CENTER		DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	checks, vitals and found nothing ab further indicated her assessment in record or notify to fattorney of the the fall to the one of her shift. RN busy at that time, excuse but it's truindicated she shounit manager, phattorney, start an reassess the reside On 2/17/16 at 11 was conducted we Practical Nurse] that on the evening 7:30 P.M., she we to come to Resid her knee, CNA # swollen and laid that upon assessment B's knee to be sweet she could not det far up the displace Resident B was so and was sitting in On 2/16/16 at 1:0 Nurses provided	2:00 A.M., an interview with LPN [Licensed #2. LPN #2 indicated as requested by CNA #1 ent B's room to assess 1 indicated it was funny. LPN #2 indicated ment she found Resident wollen and displaced but the sement went because still wearing her pants				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155689	B. WING 02/18/2016			2016	
NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER		24 G0	00 CC DSHE	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDI HAZARDS/SUPEI The facility must e environment rema hazards as is post receives adequate assistance device Based on record the facility failed assistance during accident that rest that required host leg amputation for reviewed for accident that rest that required host leg amputation for reviewed for accident B was a on 3/30/11. Dia not limited to, A muscle weaknes heart disease and pulmonary disease An annual Minim	ENT RVISION/DEVICES ensure that the resident ains as free of accident sible; and each resident e supervision and s to prevent accidents. review and interview, d to provide adequate g a transfer to prevent an ulted in a femur fracture spitalization and lower for one of three residents eidents. (Resident B)  S:  00 P.M., the clinical ent B was reviewed. admitted to the facility gnoses included but were lzheimer's disease, s generalized, pulmonary d chronic obstructive	F 0323		F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES This facility will ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Actio Resident B receives transfers with the assistance of two staff members and a mechanical lift Resident B remains free of accidents and has had no furth falls. Preventative Measure The CNA/Nurse new employed orientation check off was revis to include reading and interpreting the information included on the resident care guides to ensure adequate assistance is provided during a resident transfer. Nursing employees were re-educated of transfer technique and checke	n: ner s: e ed	03/17/2016

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/18/2016
	PROVIDER OR SUPPLIER  YARD HEALTHCARE CENTER	2400 C	ADDRESS, CITY, STATE, ZIP CODE COLLEGE AVE EN, IN 46526	_
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	indicated Resident B required extensive assist of 2 people for transfers and did not ambulate. The MDS assessment indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment.  A care plan, created on 03/30/15, indicated, but was not limited to, " At risk for falls r/t [related to] high risk medication use, impaired memory, incontinence, and inability to stand Interventions/Tasks Hoyer Lift for transfers with 2 assistDate Initiated: 05/05/13"  A resident care guide, dated 1/19/16, indicated "[Resident B] Transfer Assist H [Hoyer lift]"  A nursing progress note, dated 1/20/16 at 01:09 A.M., indicated " Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen. Resident received scheduled dose of acetaminophen [a pain medication]. MD [medical doctor] notified and received order for x-ray to left knee. POA [power of attorney] notified. Confirmed displacement. MD ordered transfer to ER [emergency room]. Resident sent to [name of local hospital] ER"		off using return demonstration Additional education included post fall procedures directing CNAs to refrain from moving resident until a licensed nurse has completed an assessmer Monitoring: The Director of Nursing/Designee will comple random audits on nursing star completing transfers using adequate assistance as indica in the plan of care 5x weekly the first month, 3x weekly for months and 2x weekly for two months. Results of this audit be presented to QAPI for nee further monitoring. Date of Completion: March 17, 2016	the ent.  Ite of the control of the

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	00	COMPL		
		155689	B. W	ING		02/18/	2016
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
COURTY	'ARD HEALTHCAR	E CENTER			OLLEGE AVE :N, IN 46526		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	A "Fall Scene In	vestigation Report"					
		te of Fall: 1/19/16Time					
	of Fall: 3:30 PM						
	_	mmary: Fall to the floor ll Location: Resident					
	,	s resident doing during or					
		Transfer assisted by					
		e of assistance was					
		g at time of fall: Assisted					
	_	e planWhat appears to					
		of the fall? CNA ng Assistant] did not use					
	correct mode to	•					
		ure [Registered Nurse					
	#1]Date and T	ime: 1/19/16"					
	A "Fall" report, o	dated 1/19/16 at 19:45					
		cated "Incident					
	Location: Reside	ent's roomPerson					
	1 0 1	t: [Licensed Practical					
	_	sing description: Nurse					
		assess edema noted to knee confirmed swollen					
		on Taken: Resident					
	received schedul						
	Acetaminophen.	MD notified and					
	received order fo	or x-ray to left knee. POA					
		ned displacement.					
	Resident sent to	-					
	hospital]Injury	type: unable to el of Pain: PAINAD					
	[sic]: 6Negativ						
		Occasional Moan or					
		xpression: 2 Facial					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155689	B. W	ING	<u> </u>	02/18/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				DLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		GOSHE	N, IN 46526		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	•	y Language: 2Rigid, Knees Pulled Up, Pulling					
	or Pushing Away	1,					
		.Distracted or Reassured					
		chMental Status:					
	Oriented to Perso						
	Situation Factors						
		itnesses: [name of					
	CNA] Relation:	-					
		ement: " I was getting					
		inner and transferred					
	resident by myse	elf with gait belt. She					
	started sitting do	wn during turn and fell					
	on floor with leg	s bent. I notified nurse					
	in charge of resid	dent [name of #Licensed					
		†1]Agencies/People					
	notified: Family						
		[8:12 P.M.]Physician					
	[name] 1/19/201	6 19:50 [7:50 P.M.]"					
	A Radiology rep	ort, dated 1/19/16,					
	C3 1	nclusion: Acute distal					
	femur displaced						
	A [name of local	hospital] consultation					
	report, dated 1/2	0/16, indicated " 81					
	year old who has	been immobile for the					
	last year had an a	accident at the nursing					
	_	her supracondylar femur.					
	She was evaluate	· -					
		pedics and between her					
		mobility and brittle					
		litation potential was					
	essentially 0. Af	fter discussing with her					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155689	B. W	ING		02/18/	/2016
NAME OF F	PROVIDER OR SUPPLIER	<u>!</u>			ADDRESS, CITY, STATE, ZIP CODE		
COURTY	ARD HEALTHCAR	E CENTER			OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		on was made for an		TAG	DEFICIENCY)		DATE
	_	e patient apparently does					
	not speak"	The state of the s					
		2:15 A.M., an interview					
		vith RN (Registered †1 indicated she had been					
	,	#1 around 3:30 P.M. on					
		that had occurred during					
	a transfer. Resid	lent B was sitting in her					
		entry to her room. RN					
		did an assessment, neuro					
		d range of motion and					
	_	onormal at the time. She she did not document					
		n the resident's clinical					
		the physician and power					
	<del>-</del>	e fall nor did she report					
		coming nurse at the end					
		#1 indicated "I was					
	-	, I know it's a poor					
		ue" RN #1 further buld have notified the					
		ysician, power of					
		incident report and					
	reassess the resid	lent"					
	0.04546	00 4 34					
		:00 A.M., an interview					
		vith LPN (Licensed #2. LPN #2 indicated					
	· ·	ng of 1/19/16 around					
		as requested by CNA #1					
		lent B's room to assess					
	her knee, CNA #	1 indicated it was					

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		IDENTIFICATION NUMBER:	l í	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
155689		B. W	ING		02/18/2016			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
COURTYARD HEALTHCARE CENTER			2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
	swollen and laid funny. LPN #2 indicated							
	that upon assessment she found Resident							
	B's knee to be swollen and displaced but							
	she could not determine at the time how							
	far up the displacement went because							
	Resident B was still wearing her pants							
	and was sitting in a wheelchair. She indicated she then notified the Nurse							
	Practitioner, the Power of Attorney and							
	the Director of Nurses.							
	On 2/17/16 at 9:00 A.M., an interview							
		vith the Director of						
	Nurses. The Director of Nurses indicated							
	that CNA#1 had completed the facilities							
	nurse aide training course and was							
		to perform a Hoyer lift						
		ther indicated CNA #1						
	was released from her employment at the facility for improperly transferring							
	Resident B.							
	On 2/16/16 at 1:00 P.M., the Director of							
	Nurses provided the policy, "Assessing							
		Causes," revision date						
		nd indicated it was one						
		y the facility. The policy						
	indicated " Ste	•						
		r a Fall: 3. Once an						
		out significant injury,						
	_	l help the resident to a ng, lying, or standing						
	position, and then document relevant detailsDocumentationWhen a							

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155689		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/18/2016			
NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  resident falls, the following information		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	should be record medical record: which the reside resident found ly bed and chair") including vital si injuries3. Intertreatment admin of the physician indicated5. Co assessment6. A taken to prevent signature and titl the data"	ed in the resident's  1. The condition in nt was found (e.g. " ring on the floor between 2. Assessment data, gns and any obvious ventions, first aid, or istered4. Notification and family, as mpletion of a falls risk appropriate interventions future falls7. The le of the person recording							

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